Birth Records Pages 1–8

580 Julie
909-0290 493-9436
RS #10
MRN 435903

Mount Clemens General Hospital

ANTEPARTUM ASSESSMENT

DATE 8-8-03	TIME 1310
HOSP. NO. 1495066	
NAME Bauner Victoria	
PHYSICIAN McWha	CONSULTING PHYSICIAN
BP 121/78	T 98.0 P 102 R 18
Edc 8/28/03	PARITY G4 P1001
US/EDC	EGA 37 LMP
Contractions: Freq. Dur. Onset	
Membranes: L R Date Time Color	
Vag. Spec.: Nitrozine Fem.	
CURRENT RX: Flagyl, PNV	
PRESENT PREG. HX N/O Labor	

VAGINAL EXAM

	1	2	3
DOCTOR	[illegible]	[illegible]	[illegible]
TIME	1315	15:40	[illegible]
DILATION	1	1	1
STATION	-2	-3	-3
EFFACEMENT	Th	50%	50%
POSITION			
FHT	120	120	
CONTRACTIONS	Occ	2-3m	

NON STRESS TEST

NON REACTIVE REACTIVE

COMMENT:

CONTRACTION STRESS TEST

SPONTANEOUS CST	NIPPLE STIM.	PITOCIN
UTERINE CONTRACTIONS (PER 10 MIN) :	Positive (Reactive) / Positive (Nonreactive)	NEGATIVE

COMMENT:

BIOPHYSICAL PROFILE

FBM (0 - NONE 1 - DECREASED 2 - NORMAL) =
FM (0 - NONE 1 - DECREASED 2 - NORMAL) =
FT (0 - NONE 1 - DECREASED 2 - NORMAL) =
AFV (0 - NONE 1 - DECREASED 2 - NORMAL) =
NST (0 - NONREACTIVE 2 - REACTIVE) =

TOTAL SCORE =

AF INDEX (cms) LUQ __.__ + LLQ __.__ + RUQ __.__ + RLQ __.__ = TOTAL __.__

NORMAL AFI (> 5CM) DECREASED (< 5CM) INCREASED (>24)

Pt states having CTX's x 3 days that were worse today + 3 min apart. Denies leaking fluid — [illegible]

[illegible]

[illegible] Ambulated x 2 hrs and rechecked. [illegible] between 2 + 3 [illegible] GBS (-) UA: Neg.

IUP @ 37 1/7 wks (Plan) (1) D/C [illegible]
[illegible] early latent labor (2) D/C home
(3) [illegible] (3) [illegible]
[illegible] + strength
(4) [illegible]
(5) [illegible]
[illegible]
delivery

TIME:		
CBC	UA	PTT
Wbc	sp. gr.	PT
Rbc	pH	Control
Hgh	Protein	FSP
HCT	Glucose	Fibrin
Mcv	Ketones	
Mch	Bili	
Mchc	Hgb	Na
RDw	Epith	K
Ptl Vol	Casts	Cl
Lymph %	Crystals	Co2
Mono %	Bacteria	
Gran %	Nitrates	BUN
Ptl Ct	Leuc	Creat
A. Lymph		SGPT
A. Mono		SGOT
A. Gran		
		Uric Acid
		RBS

HOME @ INSTRUCTIONS
ADMIT @

NURSE Braun RN
PHYSICIAN [signature]

MCGH #181040 (3/01)

WHITE - DEPARTMENT COPY YELLOW - PHYSICIAN'S COPY

Willow Pediatrics

SICK OR RECHECK VISIT

9-9-03= NS for rev. DD

Name Philipp Baumer Date of Birth 8-16-03

Date: 10/8/03 Current Age: _____ Allergies: _____

Chief Complaint: poor appetite, refused to eat, very fussy. sent ER. pfw mom. RC.

10-3-03= Catalan confirmed, patient sent to ER/dd

List any medications in the past 2 weeks, including over the counter meds:

Has the patient been seen for this reason before? ☐ No ☐ Yes Where? _____

When? _____

Pertinent Past Medical History: _____

Are the child's immunizations up to date? ☐ Yes ☐ No

Weight _____ Temp _____ Other _____

PHYSICAL EXAM	Normal	Abnormal	Description
General Appearance	☐	☐	
Skin	☐	☐	
HEENT	☐	☐	
Heart	☐	☐	
Lungs	☐	☐	
Abdomen	☐	☐	
Neurological	☐	☐	
Musculoskeletal	☐	☐	
Genitalia	☐	☐	

ASSESSMENT: _____

PLAN: _____

FOLLOW UP: ☐ Time _____

☐ As Needed

LABS: _____

Cc To: _____

Provider Signature

(Revised 4-2003)

19

Mount Clemens General Hospital

ANTEPARTUM ASSESSMENT

MG# 435703

DATE | TIME | HOSP. NO.

NAME

PHYSICIAN | CONSULTING PHYSICIAN

BP T P R

Edc PARITY

US/EDC EGA LMP

Contractions: Freq. Dur. Onset

Membranes: L R Date Time Color

Vag. Spec.: Nitrozine Fern.

CURRENT RX:

PRESENT PREG. HX

VAGINAL EXAM

	1	2	3
DOCTOR			
TIME			
DILATION			
STATION			
EFFACEMENT			
POSITION			
FHT			
CONTRACTIONS			

NON STRESS TEST

NON REACTIVE REACTIVE

COMMENT:

CONTRACTION STRESS TEST

SPONTANEOUS CST | NIPPLE STIM. | PITOCIN

UTERINE CONTRACTIONS (PER 10 MIN) : Positive (Reactive) | Positive (Nonreactive) | NEGATIVE

COMMENT:

BIOPHYSICAL PROFILE

FBM (0 - NONE 1 - DECREASED 2 - NORMAL) =

FM (0 - NONE 1 - DECREASED 2 - NORMAL) =

FT (0 - NONE 1 - DECREASED 2 - NORMAL) =

AFV (0 - NONE 1 - DECREASED 2 - NORMAL) =

NST (0 - NONREACTIVE 2 - REACTIVE) =

TOTAL SCORE =

AF INDEX (cms) LUQ + LLQ + RUQ + RLQ = TOTAL

NORMAL AFI (> 5CM) DECREASED (< 5CM) INCREASED (>24)

TIME:		
CBC	UA	PTT
Wbc	sp. gr.	PT
Rbc	pH	Control
Hgh	Protein	FSP
HCT	Glucose	Fibrin
Mcv	Ketones	
Mch	Bili	
Mchc	Hgb	Na
RDw	Epith	K
Ptl Vol	Casts	Cl
Lymph %	Crystals	Co2
Mono %	Bacteria	
Gran %	Nitrates	BUN
Ptl Ct	Leuc	Creat
A. Lymph		SGPT
A. Mono		SGOT
A. Gran		
		Uric Acid
		RBS

HOME @
ADMIT @

INSTRUCTIONS

NURSE

PHYSICIAN

MCGH #181040 (3/01)

WHITE - DEPARTMENT COPY YELLOW - PHYSICIAN'S COPY

Mount Clemens General Hospital

TR-

ANTEPARTUM ASSESSMENT

MR # 435908

DATE 8-2-03 TIME 1500 HOSP. NO. 2

NAME BAUMER VICTORIA

PHYSICIAN MAWHA CONSULTING PHYSICIAN

BP 115/73 T 98.8 P 94 R 18

Edc PARITY G4 P2012

US/EDC 8-28-03 EGA 36 2/7 LMP

Contractions: Freq. Dur. Onset

Membranes: L R Date Time Color

Vag. Spec.: (Nitrozine) neg (Fem.) neg

CURRENT RX: PNV

PRESENT PREG. HX h/o hyperemesis ⚠

VAGINAL EXAM

	1	2	3
DOCTOR	Fischaro		
TIME	15:45		
DILATION	FT		
STATION	-3		
EFFACEMENT	50		
POSITION	mid		
FHT	130		
CONTRACTIONS	irreg.		

[illegible]

25 y/o G4 P2012 ē IUP @ 36 2/7 wk
presents c/o ↓ FM "not as strong as usual".
⊕ FM 6-8x today. Also c/o vag d/c +
moisture of panties. ∅ vag bleed.
occ. ctxs ∅ dysuria
spec exam: ⊕ white d/c - thin homogenous
wetmount: ⊕ clue cells ∅ pooling

Ⓘ 1) IUP @ 36 2/7 wk — 55|24
2) BV — 33|17
3) mild dehyd
Ⓟ 1) D/C home ē PTL prec — 38+41 (12.9)
2) Flagyl 500 mg PO BID x 7d
3) ↑ fluids
HOME @ / ADMIT @ INSTRUCTIONS 4) kick count instructions
5) D/W Dr Olson

NURSE Amy [illegible] RN verbal instructions

PHYSICIAN [signature] DO — given

NON STRESS TEST

NON REACTIVE — (REACTIVE) 130's

COMMENT:

CONTRACTION STRESS TEST

SPONTANEOUS CST | NIPPLE STIM. | PITOCIN

UTERINE CONTRACTIONS (PER 10 MIN): Positive (Reactive) | Positive (Nonreactive) | NEGATIVE

COMMENT:

BIOPHYSICAL PROFILE

FBM	(0 - NONE	1 - DECREASED	2 - NORMAL) =	
FM	(0 - NONE	1 - DECREASED	2 - NORMAL) =	
FT	(0 - NONE	1 - DECREASED	2 - NORMAL) =	
AFV	(0 - NONE	1 - DECREASED	2 - NORMAL) =	
NST	(0 - NONREACTIVE	2 - REACTIVE) =		

TOTAL SCORE =

AF INDEX (cms) LUQ __.__ + LLQ __.__ + RUQ __.__ + RLQ __.__ = TOTAL __.__

NORMAL AFI (> 5CM) DECREASED (< 5CM) INCREASED (>24)

TIME:		
CBC	UA	PTT
Wbc	sp. gr.	PT
Rbc	pH	Control
Hgh	Protein	FSP
HCT	Glucose	Fibrin
Mcv	Ketones	
Mch	Bili	
Mchc	Hgb	Na
RDw	Epith	K
Ptl Vol	Casts	Cl
Lymph %	Crystals	Co2
Mono %	Bacteria	
Gran %	Nitrates	BUN
Ptl Ct	Leuc	Creat
A. Lymph		SGPT
A. Mono		SGOT
A. Gran		
	2003	Uric Acid
	BY DG	RBS

MCGH #181040 (3/01)

WHITE - DEPARTMENT COPY YELLOW - PHYSICIAN'S COPY

Mount Clemens General Hospital

ANTEPARTUM ASSESSMENT

435908

DATE 7-16-02	TIME 0215
HOSP. NO. 3416997	
NAME Bunu Victoria	
PHYSICIAN Mcuhia	CONSULTING PHYSICIAN
BP 103/56 T 98.6 P 73 R 18	
Edc 8/30	PARITY G 4 2012
US/EDC 8-30-02	EGA 35wks LMP 33 4/7
Contractions: 2	Freq. Dur. Onset
Membranes: (I) R	Date Time Color
Vag. Spec.: Nitrozine	Fem.
CURRENT RX: PNV	all NKDA
PRESENT PREG. HX	nausea / diarrhea / vomit PMH: Ø

VAGINAL EXAM

	1	2	3
DOCTOR	Dampier		
TIME	0415		
DILATION	CL		
STATION	↑		
EFFACEMENT	th		
POSITION			
FHT	120/130's		
CONTRACTIONS	irrit		

NON STRESS TEST

NON REACTIVE — REACTIVE (circled)

COMMENT: 120-130's

CONTRACTION STRESS TEST

SPONTANEOUS CST	NIPPLE STIM.	PITOCIN	
UTERINE CONTRACTIONS (PER 10 MIN)	Positive (Reactive)	Positive (Nonreactive)	NEGATIVE

COMMENT:

BIOPHYSICAL PROFILE

FBM	(0 - NONE	1 - DECREASED	2 - NORMAL) =	
FM	(0 - NONE	1 - DECREASED	2 - NORMAL) =	
FT	(0 - NONE	1 - DECREASED	2 - NORMAL) =	
AFV	(0 - NONE	1 - DECREASED	2 - NORMAL) =	
NST	(0 - NONREACTIVE	2 - REACTIVE) =		

TOTAL SCORE =

AF INDEX (cms) LUQ __.__ + LLQ __.__ + RUQ __.__ + RLQ __.__ = TOTAL __.__

NORMAL AFI (> 5CM) DECREASED (< 5CM) INCREASED (>24)

Presents to triage c/o vomiting x2 diarrhea x3 and occasional "tightening" since 0001. Membranes intact. (+) FM. Suspects food poisoning from Kentucky Fried Chicken. ECM applied. FHR 115-130 reactive.

Pt is a 25 y/o G4 P2012 @ 33 4/7 presents c nausea, vomiting and diarrhea since 2400 when woke up. Pt ate KFC and pizza around 1900. Pt denies any abdominal pain, Ø F/C, Ø H/A, Ø SCB Ø CP, Ø SUI, contracts. Øhematemesis Ø blood in stool

ABD: soft, NT, gravid. No G/R/R.

- Pt given IV fluids, Phenergan 25mg - reports less nauseous, Ø further emesis, diarrhea x1

A. ① IUP @ 33 4/7 P. ① D/C home

② Gastroenteritis ② PTL precautions

③ GBS cult sent ③ ↑ po hydration

④ return if unable to

HOME / ADMIT INSTRUCTIONS: as above

NT Hold Dict?

return if unable to tolerate PO po fluids, fevers, blood

⑤ F/U in clinic as scheduled

⑥ D/W Dr Mabey

NURSE C Kelvin RN instructed vomiting

PHYSICIAN Dampier / [signature]

TIME:		
CBC	UA	PTT
Wbc 10.8	sp. gr. 1.025	PT
Rbc	pH 6.5	Control
Hgh 10.0	Protein	FSP
HCT 29.7	Glucose	Fibrin
Mcv	Ketones	
Mch	Bili	
Mchc	Hgb	Na
RDw	Epith	K
Ptl Vol	Casts	Cl
Lymph %	Crystals	Co2
Mono %	Bacteria	
Gran %	Nitrates	BUN
Ptl Ct	Leuc small	Creat
A. Lymph		SGPT
A. Mono	WBC 5-10	SGOT
A. Gran	[illegible]	
		Uric Acid
		BBS

MCGH #181040 (3/01)

WHITE - DEPARTMENT COPY YELLOW - PHYSICIAN'S COPY

Mount Clemens General Hospital

Results Report

03/12/03 13:24

Baumer, Victoria 25Y [ER] E2442387-5 M0435908-1 Delong, Glenn A., DO ...continued

Start Time	Complete Time	Procedure	Result	Low	High	Flag	Delta
03/05/03 12:15	03/05/03 20:23	Chlamydia/GC-DNA Probe	Completed				
	03/05/03 20:18	Chlamydia-DNA Probe	NEGATIVE				
	03/05/03 20:18	GC DNA Probe	NEGATIVE				
	03/05/03 13:16	Hanging Drop/Trichomona	-			High	
		MOTILE TRICHOMONAS SEEN					
		CBC/Automated Diff					
03/05/03 12:02	03/05/03 12:13	White Blood Cell Count*	8.5 x 1000/mm3	3.6	10.5		
	03/05/03 12:13	Red Blood Cells*	3.85 mil/mm3	3.57	5.13		
	03/05/03 12:13	Hemoglobin*	11.5 gm/dl	11.3	15.1		
	03/05/03 12:13	Hematocrit*	33.6 %	34.1	45.0	Low	
	03/05/03 12:13	Mean Corpuscular Volume	87.3 fL	80.0	100.0		
	03/05/03 12:13	MCH Concentration	34.3 gm/dl	33.2	35.4		
	03/05/03 12:13	Mean Corpuscular HGB	29.9 pg	27.1	33.9		
	03/05/03 12:13	Platelet Count*	194 x 1000/mm3	140	400		
	03/05/03 12:13	Neutrophils %	71 %	43	72		
	03/05/03 12:13	Lymphocytes %	21 %	17	44		
	03/05/03 12:13	Monocytes %	5 %	3	12		
	03/05/03 12:13	Basophils %	1 %	0	2		
	03/05/03 12:13	Eosinophils %	3 %	0	6		
03/05/03 12:13	03/05/03 12:13	Absolute Neutrophil	6.04 thou/mm3	1.80	6.70		
03/05/03 12:02	03/05/03 12:13	Absolute Lymphs	1.8 thou/mm3	0.8	3.1		
	03/05/03 12:13	Absolute MONO	0.43 thou/mm3	0.20	0.80		
	03/05/03 12:13	Absolute BASO	0.09 thou/mm3	0.00	0.20		
	03/05/03 12:13	Absolute EOS	0.26 thou/mm3	0.00	0.50		
	03/05/03 12:13	Mean PLT Volume	7.9 fL	7.5	11.5		
	03/05/03 12:13	RBC Distribution Width	12.8 %	11.5	14.5		
	03/05/03 13:45	HCG-Quantitative,Serum	Completed				
	03/05/03 13:40	HCG-Quantitative	21368.1 miu/ml				

Beta HCG Expected values for Pregnancy

0.2-1 week = 5-50 miu/ml | 4-5 weeks =1,000-50,000 miu/ml

1-2 weeks = 50-500 miu/ml | 5-6 weeks = 10,000-100,000 miu/ml

2-3 weeks = 100-5,000 miu/ml | 6-8 weeks = 15,000-200,000 miu/ml

3-4 weeks = 50

03/05/03 12:02 03/05/03 13:40 IMPORTANT BHCG MESSAGE:

PLEASE NOTE:
This HCG QUANTITATIVE result is for the detection of pregnancy
ONLY. It is NOT to be used for the diagnosis or monitoring of
tumors. A BHCG TUMOR MARKER test must be requested for that purpose.

MOUNT CLEMENS GENERAL HOSPITAL
1000 Harrington Blvd. MOUNT CLEMENS MI 48043
DAILY REPORT

Patient name: **BAUMER, VICTORIA**
Patient phone: 5864663843
Location: WOMEN'S HEALTH-MT CLEMENS
Adm.date: 01/31/03 Surg.date:

M.R.N.: 4359081 Room: COUR
Billing no.: 53474469
Att.physician: ALDERSON, THOMAS
DOB: 10/22/1977 Age: 25 Sex: F

FINAL

Order Id : D33[illegible]643
Date&Time Ordered: 01/31/03 20:35
Req.physician : **ALDERSON, THOMAS**
Report to : **ALDERSON, THOMAS**

Address: ALDERSON, THOMAS

U A D R U G T E S T I N G

TEST-NAME	RESULT	AB	NRML-RANGE	UNITS
UA DRUG SCREENING TEST				
SPECIMEN UR1 COLLECTED 01/31/03 20:35 BY 6419 RECEIVED 01/31/03 20:35 BY				
AMPHETAMINE SCREEN-UA	NEGATIVE			
BARBITURATE SCREEN-UA	NEGATIVE			
BENZODIAZEPINE SCREEN U	NEGATIVE			
CANNABINOID SCREEN-UA	**POSITIVE**	**AB**		
COCAINE SCREEN-UA	NEGATIVE			
OPIATE SCREEN-UA	NEGATIVE			
METHADONE SCREEN-UA	NEGATIVE			
PROPOXYPHENE SCREEN-UA	NEGATIVE			
PHENCYCLIDINE SCREEN-UA	NEGATIVE			
THRESHOLD CUT-OFF LEVEL	SEE BELOW			

DRUG CLASS	CUT OFF LEVEL	
AMPHETAMINES	1000 NG/ML	
BARBITURATES	200 NG/ML	(EFFECTIVE 10 AM 12/20/02 PREVIOUS CUTOFF = 300 NG/ML
BENZODIAZEPINES	200 NG/ML	
CANNABINOIDS	50 NG/ML	
COCAINE	300 NG/ML	
METHADONE	300 NG/ML	
OPIATES	2000 NG/ML	
PHENCYCLEDINES (PCP)	25 NG/ML	
PROPOXYPHENES	300 NG/ML	

**NOTE: Sympathomimetic Amines may show a positive result for Amphetamines class

continued on next page

Mount Clemens, Aug. 16–23, 2003 Pages 9–18

Moun. Clemens General Hospital

Discharge Summary

1000 Harrington Blvd. Mt. Clemens, MI 48043 (586) 493-8000

Name	Date of Birth	Room	Exam Date	Encounter#	MR#
Baumer, Babyboy	**08/16/2003**	**NSC0**	**08/23/03**	**E2497053-7**	**M0764386-1**

REPORT COPIES TO: Lucila Olson, MD
Attending: Bahman Mehdizadeh, MD

DATE OF ADMISSION: 08/16/03
DATE OF DISCHARGE: 08/23/03

HISTORY: This baby was born on 08/16/03, to a 26-year-old gravida 4, para 2, AB 1 with history of some marijuana use and tobacco use in pregnancy. Otherwise, she was a healthy woman. Delivery was at 38-0/7ths weeks gestational age. The baby's Apgar scores were 8 at one minute and 8 at five minutes. The baby was maintained initially in well baby nursery. Birth weight had been 6 pounds 11 ounces. The baby was noted to have some feeding difficulties with both emesis and very poor feeding. He was transferred to the special care nursery and eventually his emesis progressed to quite a significant amount. He was made NPO and a barium swallow which was done which revealed mild reflux into the esophagus without evidence of pyloric stenosis or abnormalities. He was begun on thickened feedings with Enfamil AR and eventually began to nipple all of his feedings with some gavaging and has been retaining. He had a mild hyperbilirubinemia, his highest value being 12.9, and his value is down to 10 by discharge. A drug screen was done which was negative for all substances. There were no significant fluid or electrolyte derangements and by the time he was discharged the baby was nipping between 1-1/2 and 2 ounces of Enfamil AR and retaining. His weight is up almost 2 ounces the day prior to discharge, back up to 6 pounds 6 ounces and he was ready for discharge to home.

The patient will be seen by Dr. Lucila Olson for general pediatric care.

FINAL DIAGNOSES:
1.Feeding problem, nonspecific.
2.Gastroesophageal reflux disease.
3.Term AGA male.
4.Maternal substance use in pregnancy.

Job No: 01610
DD: 08/23/03
DT: 08/29/03
D: Gail A. Abraham, MD

Mount Clemens General Hospital
24 HOUR NEWBORN PATIENT CARE RECORD

09764386-1 E2497053-7
Baumer, Babyboy
DOB: 08/16/03 M 0D
Date: 08/16/2003 17:50
Olson, Lucila W., MD

09

TIME(s): 2330 0700 Initials: [illegible]

COGNITIVE / PERCEPTUAL
LOC: ☒ Awake ☐ Non-Responsive
AROUSABLE: ☒ Voice ☒ Touch ☐ Pain
FONTANELLE: ☐ Bulging ☐ Sunken ☒ Soft ☒ Open ☐ Closed
MOBILITY
Moves all extrem ☐ No ☒ Yes
☐ Weak ☐ RA ☐ LA ☐ RL ☐ LL ☐ Tremors
REFLEXES: Moro, Grasp, Suck ☒ Intact ☐ Absent ☐ Weak
☐ Harness ☐ Spec. Diapering ☐ Clavicle pos.
RESPIRATORY
Respirations: ☒ Even ☐ Retractions ☐ Nasal Flaring ☐ Grunting
☐ Use of Accessory Muscles Chest Shape ☒ Symmetrical
Breath sounds ☒ Clear & Equal ☐ Ronchi ☐ Wheeze ☐ Crackles
☐ Diminished ☐ Rales ☐ Coarse ☐ Grunting
CIRCULATORY
Color ☒ WNL ☐ Pale ☐ Cyanotic ☐ Jaundice ☐ Mottled
Capillary Refill: ☒ Brisk ☐ Sluggish

NUTRITION / METABOLIC PATTERN
Abdomen: ☒ Soft ☐ Firm ☒ Non-Distended ☐ Distended
Bowel Sounds ☒ WNL ☐ Absent ☐ Hyper ☐ Hypoactive
Skin Integrity: ☒ Intact ☐ Breakdown Site Description _____
Diet: ☐ NPO Formula Strength: Similac advanced
☒ Retaining Feeds ☒ Suck Adequate ☒ Swallow w/o difficulty
☐ Cleft Lip ☐ Palate
ELIMINATION ☒ Voiding ☐ Anuria ☒ Genitalia Normal
☒ Meatus placement normal ☒ Testes desc. bil.
HYGIENE
☐ Complete Bath ☐ Partial Bath x _____: ☐ 1 Assist ☐ 2 Assist
☒ Linen Change ☒ 1 Assist ☐ 2 Assist ☐ 3 or >
PARENT INTERACTION
☒ Responding to Infant Cues ☒ Holding Infant
☐ Participating Incare ☐ Visiting Infant ☒ Feeding Infant

TIME(s): 0830 _____ Initials: MV

COGNITIVE / PERCEPTUAL
LOC: ☒ Awake ☐ Non-Responsive
AROUSABLE: ☐ Voice ☒ Touch ☐ Pain
FONTANELLE: ☐ Bulging ☐ Sunken ☒ Soft ☒ Open ☐ Closed
MOBILITY
Moves all extrem ☐ No ☒ Yes
☐ Weak ☐ RA ☐ LA ☐ RL ☐ LL ☐ Tremors
REFLEXES: Moro, Grasp, Suck ☒ Intact ☐ Absent ☐ Weak
☐ Harness ☐ Spec. Diapering ☐ Clavicle pos.
RESPIRATORY
Respirations: ☒ Even ☐ Retractions ☐ Nasal Flaring ☐ Grunting
☐ Use of Accessory Muscles Chest Shape ☐ Symmetrical
Breath sounds ☒ Clear & Equal ☐ Ronchi ☐ Wheeze ☐ Crackles
☐ Diminished ☐ Rales ☐ Coarse ☐ Grunting
CIRCULATORY
Color ☒ WNL ☐ Pale ☐ Cyanotic ☐ Jaundice ☐ Mottled
Capillary Refill: ☒ Brisk ☐ Sluggish

NUTRITION / METABOLIC PATTERN
Abdomen: ☒ Soft ☐ Firm ☐ Non-Distended ☐ Distended
Bowel Sounds ☒ WNL ☐ Absent ☐ Hyper ☐ Hypoactive
Skin Integrity: ☒ Intact ☐ Breakdown Site Description _____
Diet: ☐ NPO Formula Strength: _____
☐ Retaining Feeds ☐ Suck Adequate ☐ Swallow w/o difficulty
☐ Cleft Lip ☐ Palate
ELIMINATION ☒ Voiding ☐ Anuria ☒ Genitalia Normal
☐ Meatus placement normal ☐ Testes desc. bil.
HYGIENE
☐ Complete Bath ☐ Partial Bath x _____: ☐ 1 Assist ☐ 2 Assist
☒ Linen Change ☐ 1 Assist ☐ 2 Assist ☐ 3 or >
PARENT INTERACTION
☒ Responding to Infant Cues ☒ Holding Infant
☒ Participating Incare ☐ Visiting Infant ☒ Feeding Infant

TIME(s): 1500 - 1150 Initials: ME

COGNITIVE / PERCEPTUAL
LOC: ☑ Awake ☐ Non-Responsive
AROUSABLE: ☑ Voice ☑ Touch ☐ Pain
FONTANELLE: ☐ Bulging ☐ Sunken ☑ Soft ☐ Open ☐ Closed
MOBILITY
Moves all extrem ☐ No ☑ Yes
☐ Weak ☐ RA ☐ LA ☐ RL ☐ LL ☐ Tremors
REFLEXES: Moro, Grasp, Suck ☐ Intact ☐ Absent ☐ Weak
☐ Harness ☐ Spec. Diapering ☐ Clavicle pos.
RESPIRATORY
Respirations: ☑ Even ☐ Retractions ☐ Nasal Flaring ☐ Grunting
☐ Use of Accessory Muscles Chest Shape ☐ Symmetrical
Breath sounds ☐ Clear & Equal ☐ Ronchi ☐ Wheeze ☐ Crackles
☐ Diminished ☐ Rales ☐ Coarse ☐ Grunting
CIRCULATORY jaundice
Color ☒ WNL ☐ Pale ☐ Cyanotic ☐ Jaundice ☐ Mottled
Capillary Refill: ☐ Brisk ☐ Sluggish

NUTRITION / METABOLIC PATTERN
Abdomen: ☑ Soft ☐ Firm ☐ Non-Distended ☐ Distended
Bowel Sounds ☐ WNL ☐ Absent ☐ Hyper ☐ Hypoactive
Skin Integrity: ☑ Intact ☐ Breakdown Site Description _____
Diet: ☐ NPO Formula Strength: Similac
☐ Retaining Feeds ☐ Suck Adequate ☐ Swallow w/o difficulty
☐ Cleft Lip ☐ Palate
ELIMINATION ☐ Voiding ☐ Anuria ☐ Genitalia Normal
☐ Meatus placement normal ☐ Testes desc. bil.
HYGIENE
☐ Complete Bath ☐ Partial Bath x _____: ☐ 1 Assist ☐ 2 Assist
☐ Linen Change ☐ 1 Assist ☐ 2 Assist ☐ 3 or >
PARENT INTERACTION
☐ Responding to Infant Cues ☑ Holding Infant
☐ Participating Incare ☐ Visiting Infant ☑ Feeding Infant

62

Mount Clemens General Hospital
Radiology Report

1000 Harrington Blvd. Mount Clemens, Michigan 48043 (586) 493-8000

Patient Name	DOB	Room	Date of Service	Encounter#	MR#
BAUMER, BABYBOY	08/16/2003	NSC05	08/20/2003	E2497053	M764386

REPORT COPIES TO:

FINAL COPY

Attending: BAHMAN B. MEHDIZADEH, MD

UPPER GI: Upper GI examination was carried out on 08/20/03. A scout film prior to this study reveals a nasogastric tube present with its tip in the region of the stomach. There is gas within the stomach and gas within the colon and small bowel.

Barium was administered. The esophagus distended satisfactorily with no evidence of fistula or stricture. as Barium enters the stomach, there was some reflux around the tube into the esophagus consistent with some mild reflux being present. The stomach distends satisfactorily. There is some delay in passage of contrast into the duodenal cap; however, this was accomplished within approximately 5 minutes time, and the patient spilled into the duodenal cap with fill of the sweep and identification of the ligament of Treitz without evidence of pyloric stenosis.

IMPRESSIONS:

1. Mild reflux into the esophagus.
2. No evidence of pyloric stenosis.
3. Ligament of Treitz identified.
4. Additional findings as described above.
5. This study was discussed with Dr. Mehdizadeh on this date.

Job No.: 29816 /tb
DD: 08/20/2003
DT: 08/20/2003 18:37:47

This document was electronically signed by DOUGLAS L. ROSS, DO on 08/21/2003 11:27:32.

96

CB :: :: NR09

Mount Clemens General Hospital
Integrated Progress Record

2497053-7 M 000 0
BAUHER, BABYBO Y
OLSON, LUCILA W MD
764386-1
CASH

DATE	TIME	DISCIPLINE	
8-17-03	0900	NSG	Mom stated "she's having a hard time for the baby to eat". stated she is spitting-up and gagging & respiratory distress noted. Fed by staff, able to tolerate 20cc but noted baby spitting up and gagging. Dr. Weidner in to see baby, made aware of mom's concern & feeding patterns. → Amuegan
	1100		Discussed to mom the plan of care. Changed formula to Isomil and feed q 2°, mom verbalizes understanding will follow-up. → Amuegan
	1300		mom attempted feeding the baby. tolerated 5cc of isomil & regurgitation, & spitting-up noted. will monitor. → Augan
	1500		Dr. Weidner notified about baby's feedings ordered a neonatology consult. Dr. Maitch notified. → Augan
	1505		Dr. Maitch notified & new orders made. → Amuegan

Please Remember to Time, Date, and Sign All Entries

206425 (12/01)

80

NR09

2497053-7 M 000 0
BAUNER, BABY BO Y Baumer
OLSON, LUCILLE
764386-1
CASH

Mount Clemens General Hospital

Multidisciplinary Care Plan Record

DATE	TIME	DISCIPLINE	
8-17-03	0600	Nsg 1	Progressing toward discharge goals. ——— [signature]
8-17-03	0800	Nsg 2	Progressing toward discharge goals ē exception ——— [signature]
8/17/03	1800	Nsg	pt admitted to SCN placed on radiant warmer, PIV started in (L) hand, Lytes, Ca, BUN + creatinine sent, PKU drawn. Temp + VSS @ this time. color pink, perfusion < 2 sec. ——— R.D. [signature] RNC
8/17/03	2000	Nsg	Fed infant lacto free 10 cc's then pt had forceful regurg of ~10 cc's of formula gave pt another 10 cc's followed by a ~3cc emesis ——— R.D. [signature] RNC
8/17/03	2130	Nsg	pt had another emesis of ~5 cc's of curdled formula, one touch 134. Dr. Maitah notified. pt made NPO, IVF Δ'd to D5.2NS ē ↑ in TFG to 120cc/kg/day and more lytes ordered for the am (K+6.9 ē 1830 lytes). pt's abd sl distended, remains soft, ⊘ bowel loops. R.D. [signature] RNC
	late entry from		
8/17/03	1500	Nsg	(late entry) pt. brought to SCN earlier today @ 1500 for CBC BC + (L) [illegible] R.D. [signature]

Please Remember to Time, Date and Sign All Entries

87

Form # 1525 Pg.2 (12/02)

07 24 03 NF05

Mount Clemens General Hospital

Integrated Progress Record

Baby Boy Bauman
BAUMAN BABY BOY
244912622, BAHMAN MD
C2:6493861

DATE	TIME	DISCIPLINE	
8-17-03	1825	CSW:	Drugscreen protocol initiated due to maternal hx and ⊕ prenatal uds '03. Mom neg @ admit. Mom has support of sister and family. Has gathered baby/nursery items. Will stay w/ her parents until able to locate own housing. Mom has stabilized situation since beginning of pregnancy. Is linked to community resources. Mom with ⊕ bonding and attachment to baby. Can attempt f/u pp @ WBA MC with mom. Plan: Baby home to mom once stable per SCN. No other CSW needs presently id'ed. [signature] MSW ACSW #2143
8.18.03	7:45		Neo/OB Resident
	Ⓢ		2 day old male neonate born via SVD @ 38 ⁰/₇ wk s̄ difficulty. Birth wt 6# 8oz/2948gm. Pt transferred to SCN 2° to poor feeding and vomiting x 2. Mother had ⊕ THC on 1/03 (neg @ admit). Made NPO. Abd xray - neg
Meds			BC pending, mec. drug screen pending
- ampicillin			8/18 137 | 107 | / 5.6 | 19 | ; 8/17 19.4 / 16.7 / 57.4 / 162
- cefotaxime			
- DS.2			
	Ⓞ		VS: 99°, ≡ 52, 138, 65/49 (Wt. 2961, ↓ 50 gm)
			Gen: alert, awake
			Heent: NC, mild bruising of face
			H: RRR L: CTAB, ⊖ RRW, ⊖ rhonchi
			A: soft, ND, ⊖ organomegaly, +BS ↓

Please Remember to Time, Date, and Sign All Entries

78

206425 (12/01)

0 24 03 ... N.05

2497053-7 M 010 0
BAUMER, BABYBOY
MEHDIZADEH, BAHMAN MD
764386-1
CASH

Mount Clemens General Hospital

Multidisciplinary Care Plan Record

DATE	TIME	DISCIPLINE	
8/18/03	0630	N86	VSS. Infant transferred to Isolette @ 0001 for observation. ∅ Emesis this shift. Abd. Remains slt distended ā B8X-4 quad. Infant Alert & Active. Infant Remains NPO. Infant rested & dev. Care in progress. [signature], RN
8-18-03	0830	nsg	IV site edematous ē leaking noted @ insertion site. IV removed and new peripheral IV restarted RA ē 24G [illegible], baby tolerated well. [signature]
8-18-03	0945	nsg	Abd. X ray done, result viewed by Dr. Mehdizadeh, order received to start feeding baby by gavage. NGT inserted and secured @ 19.5cm, baby tolerated feeding of 10cc well. ∅ emesis, will cont. to monitor. VSS see flow sheet. mom visited baby, held infant, updated on plan of care ē all questions answered. Will monitor [signature]
8-18-03	1430	nsg	One touch glucose 118. P.O. feeds tolerated well so far. ∅ emesis. Abd. soft not distended. [signature]
[illegible] 8-03	1000	nsg	feeding ↑ to 20cc. Nippled vigorously ∅ regurg. Isolette Δ to air control to wean to crib. set @ 31.0 infant dressed in t-shirt. Will monitor [signature]

Please Remember to Time, Date and Sign All Entries

Form # 1525 Pg.2 (12/02)

07 24 03 NTO5

Mount Clemens General Hospital

2197053-7 M CIO 0
BAURER, BABYBO Y
MEHDIZADEH, BAHMAN MD
764386-1
CASH

Multidisciplinary Care Plan Record

DATE	TIME	DISCIPLINE	
8-19-03	1300	nrsg	IV leaking b4, new IV started in scalp, baby tolerated well. Nippled 25cc of Sim, good + retained. Will monitor Knedl LPN
8-19-03	1500	nrsg	Bradycardia to 80's, ø desats, ø color Δ. Dr. Mehdizadeh aware, will monitor closely Knedl LPN
8-19-03	1900	NSG	Infant nippled 35cc. Sim well. Infant tol. & Retained feeding. Low resting HR noted c HR 90-110, will continue to monitor. ø signs distress. Infant nested + dev. care in progress. Waitmann, RN
8-20-03	0400	NSG	Infant nippled 30cc fair c much ~~coordination~~ error encouragement. Infant sleepy (2 p 30min). Remainder of feeding gavaged. Infant tol & Retained feeding ø Emesis S. Waitmann
8-20	~~0800~~ 0750		To x-ray c nurse
	0820		Returned from x-ray - UGI will be done approx 11A McCallum
8/20	1055 → 1145		Down to x-ray for UGI. Returned c nurse. tol well - fed fair + retained
	1200		Mom @ bedside McCallum

Please Remember to Time, Date and Sign All Entries

Form # 1525 Pg.2 (12/02)

07 24 03 NT05

Mount Clemens General Hospital

2497053-7 M 01D 0
BAUHER, BABYBO Y
MEHDIZADEH, BAHMAN MD
764386-1
CASH

Multidisciplinary Care Plan Record

DATE	TIME	DISCIPLINE	
8-20-03	1800	Nsg	Unable to flush H/L - dcd
			fed fair + retained — M Calleton
8-21-03	0530	Nsg	Infant nipples fair to well throughout
			night. Retained all feeds. Infant had
			two large stools (+) barium. Developmental
			care in progress — K Workers
8-21-03	0730	Nsg	Jaundiced + sleepy
	0800		m SBR drawn & to lab
	1030		nippled fair + retained. Dr Mehdizadeh
			notified of lab result
	1330		nippled well + retained
	1630		nippled fair part of feed + gavaged rest
	1700		Mom in to visit
	1800		No RDS. Remains jaundiced M Calleton
8-22-03	0900	Nsg	Baby in open crib. NGT in place developmen-
			tal care in progress. Result of bili level
			to Dr. Mehdizadeh & new orders. Baby
			nipples feedings fairly well, gavage
			remaining amounts. Mom visited and
			held baby, updated on plan of care
			[illegible]

Please Remember to Time, Date and Sign All Entries

84

Form # 1525 Pg.2 (12/02)

07 24 03 .T05

Mount Clemens General Hospital

Integrated Progress Record

2497053-7 # 010 0
BAUMER, BABYBO Y
MEHDIZADEH, BAHMAN MD
254386-1
CA04

DATE	TIME	DISCIPLINE	
8/21/03	0815	Neo	(Cont)
			2) Respiratory
			Lungs CTAB good air exchange. Pink on RA. O2 sat in mid to high 90's.
			3) GI
			No more vomiting on Enfamil AR. still needs gavage feeding. Voiding and stooling regularly. Barium Swallow diagnostic for GE Reflux & any other abnormal findings.
			4) ID
			sepsis Ruled out. BC negative.
			5) Neuro:
			Moving all extremities. Neonatal reflexes ++ and Symmetrical. Normal Muscle tone. AF open + flat
			6) Jaundice.
			Bili this AM 11.3 mg/dl. (↓ from 12.9 mg/dl on 8/21/03).
			7) F/N/E.
			TF G @ 150 ml/kg/day.
			Lytes 137.5 / 5.6 | 107.9 / 19.1 (Cont) [signature]

Please Remember to Time, Date, and Sign All Entries

206425 (12/01)

07 24 03 NTOS

2497053-7 M 010 0
BAJREK, BABYBO Y
MLADIZADEH, BAHMAN MD
764386-1
CASH

Mount Clemens General Hospital

Multidisciplinary Care Plan Record

DATE	TIME	DISCIPLINE	
8-22-03	1800	nrsg	This infant is nippling only fairly good, needs a lot of encouragement and chin support to finish feedings. Voiding, voiding, see flow sheet for VS and other data. 0 A, B, or D's noted this shift. Knedl Le
8-23-03	0000	nrsg	Infant nippled well, retaining feeds. NGT removed, order received to discharge baby home. Knedl Le
8-23-03	0945	nrsg	Discharge instructions explained to mom and she verbalized understanding of entire conversation. Discharge documents signed and ID # x 2 mother, infant escorted to car and baby discharged to care of his mother. Knedl Le

Please Remember to Time, Date and Sign All Entries

Form # 1525 Pg.2 (12/02)

Home, Aug. 23 to Oct. 2, 2003 Page 19

Willow Pediatrics

SICK OR RECHECK VISIT

Name Phelipp Raumer. Date of Birth 8-16-03

Date: 9-29-2003 Current Age: 13 days Allergies: NKDA

Chief Complaint: leg twitching when stacking it out, tounge twitches when taking bottle out of mouth (B)
6 episodes, no turning blue/or pale, no rolling back of eyeballs, appetite good, 2-2½ oz q 2-3 hrs
Stool 3-4x/day, voids 7-8x/day

List any medications in the past 2 weeks, including over the counter meds: —

Has the patient been seen for this reason before? ☒ No ☐ Yes Where? _____
When? _____

Pertinent Past Medical History: _____

Are the child's immunizations up to date? ☒ Yes ☐ No

Weight 7 Temp 97.8 Other _____

PHYSICAL EXAM	Normal	Abnormal	Description
General Appearance	☑	☐	
Skin	☑	☐	
HEENT	☑	☐	
Heart	☑	☐	
Lungs	☑	☐	
Abdomen	☑	☐	
Neurological	☑	☐	
Musculoskeletal	☑	☐	
Genitalia	☑	☐	

ASSESSMENT: Tremors

PLAN: Observe
Reassurance
If persistent need re check

FOLLOW UP: ☐ Time _____
☐ As Needed

LABS: _____

Copy To: _____

Provider Signature

(Revised 4-2003)

192

Mount Clemens, Oct. 3, 2003 Pages 20–26

Mount Clemens General Hospital

LABOR / DELIVERY SUMMARY

DATE 8/16/03

3045-3 F 25Y 5
BAUMER, VICTORIA
ALDERSON, THOMAS L DO
435908-1

G 4 T 2 P 0 A 1 L 2 EDD 8/30/03 Gest Age 38wks wks Blood Type A+

Prenatal Events ☐ None
☐ No Prenatal Care
☐ Preterm Labor (≤ 37 weeks)
☐ Post term Labor (≥ 42 weeks)
☒ Prenatal Complications tobacco abuse
4/10 (+) UDS-THC 0543 Talwin 30mg IV 8/16/03

Intrapartum Events ☐ None
☐ Febrile (≥ 100.4F)
☐ Bleeding — site undeterm
☐ Preeclampsia
☐ Seizures
☒ Medications

Membrane Assessment
Date 8/16/03 Time 0934
☒ Clear ☐ SROM ☒ AROM
☐ Premature ROM ☒ Prolonged ROM
☐ Preterm ROM ☐ Odor
☐ Polyhydram ☐ Bloody
☐ Oligohydram ☐ Mec stain (type) ______

Labor
☒ Induction
☐ Cervical Ripening
☒ Oxytocin
☒ AROM
☒ Augmentation
☐ Attempted
☐ Precep Labor (<3hrs)
☐ Prol Labor (> 20hrs)
☐ Prol 2nd Stage (> 2.5 hrs)

Monitoring
☒ External
☒ Internal
☐ Bradycardia
☐ Tachycardia
☐ Sinusoidal Pattern
☐ Accelerations
☐ Variable Decelerations
☐ Late Decelerations

Presentation
☒ Vertex
☐ Face
☐ Brow
☐ Compound
☐ Breech
☐ Single Footling
☐ Complex
☐ Transverse Lie
☐ Cord Prolapse
☐ Shoulder
☐ CPD
☐ Frank Breech
☐ Double Footling

Delivery ☒ LDRP ☐ OR
☒ NSVD
☐ VBAC
☐ Forcep ☐ Outlet
☐ Low ☐ Mid type ______
☐ Vacuum ____ min ____ kg/cm²
Fetal Position: ______
☐ Breech
☐ Spontaneous
☐ Forcep Assist

Surgical Data
☐ C-Section ☐ Prim ☐ Sec ☐ Emerg
☐ Repeat (x) ☐ Urgent

Operative Indication
☐ Previous Uterine Surgery
☐ Failure to Progress
☐ Placenta Previa
☐ Other
☐ Abruptio Placenta
☐ Fetal Malpresentation
☐ Non reassuring FHR

Episiotomy ☐ None ☒ Midline ☐ Mediolateral L R
☐ Laceration/Epis Extension
☐ Cervical
☐ Vagina
☐ Periurethral
☐ Perineal
☐ 1st degree
☒ 2nd degree
☐ 3rd degree
☐ 4th degree
Repair Agent Used: 2 0 Chromic

Uterine Incision
☐ Low Cervical, Transverse
☐ Low Cervical, Vertical
☐ Hysterectomy ☐ No ☐ Yes
☐ Tubal Ligation ☐ No ☐ Yes
☐ Sponge counts correct
☐ Pfannenstiel
☐ Classical
☐ Needle counts correct

Placenta
Configuration ☒ Normal ☐ Abnormal
☐ Spontaneous
☐ Expressed
☐ Manual Removal
☐ Adherent (type) ______
☐ Uterine Exploration
☐ Curettage
Disposition: ______

Cord
☐ Nucal (x)
☐ 2 vessels
☒ 3 vessels
☐ True Knot
☐ Cord Blood to lab
compound Rt hand

Anesthesia ☒ Epidural ☐ Local ☐ Spinal ☐ General

Delivery Medications

	Time	Dose	Route

Chronology

	Date/Time		Duration
Onset of Labor	8/16/03	0800	
Full Dilation	8-16-03	1740	
Delivery of Infant	8-16-03	1750	
Delivery of Placenta	8-16-03	1751	

Total Labor 9:51

Infant Data Time of Birth 17:50
☐ Female ☒ Male Birth Order ☐ A ☐ B ☐ C

Apgar	HR	RR	Mus Tone	Reflex	Color	Total
1 min	2	2	2	2	0	8
5 min	2	2	2	2	0	8
10 min						

Delivery Personnel
RN (1) [illegible]
RN (2) [illegible]
Anes/CRNA [illegible] MD/NA
CNM ______
Delivery Physician [illegible]
Phys Assist (1) ______
Phys Assist (2) [illegible]
Infant Care Provider [illegible]
☒ Notified ☐ Present at Birth

Sc[illegible]d by
☒ Bulb suction
☐ Suction catheter [illegible] ☒ Mouth ☐ Pharynx ☒ Nose
Size ______ fr. Pres ______ mmHg
☐ Oxygen ______ L/min ☐ Endo tube ______ size
☐ Visualize cords ☐ Mec below cords ☐ Bag & Mask
☐ Resuscitation

Mount Clemens General Hospital

E.R. Admit

1000 Harrington Blvd. Mt. Clemens, MI 48043 (586) 493-8000

Name	Date of Birth	Room	Exam Date	Encounter#	MR#
Baumer, Philipp	**08/16/2003**	**ER**	**10/03/03**	**E02513597**	**M0764386**

REPORT COPIES TO:
Attending: CHARLES D. MOK, DO
Referring:
Family: LUCILA OLSON, M.D.

PATIENT ADMITTED

FINAL DIAGNOSIS(ES):
1. Severe dehydration.
2. sepsis.
3. Acute renal failure secondary to severe dehydration.
4. Anemia, probably secondary to hemolysis.
5. Hyperkalemia.
6. Hypoglycemia.
7. Apnea.
8. Positive Gastroccult.
9. Possible intracranial hemorrhage.

CHIEF COMPLAINT: Decreased activity level.

HISTORY OF PRESENT ILLNESS: The patient is a 57-day-old white male who presents to emergency department with decreased level of activity according to the mother. The mother initially states that she has not seen the patient for three days, but other reports given to the social worker state that she has not seen the patient up to a month and currently the child is being taken care of by the patient's sister. The patient's caretaker states that yesterday he was doing fine. Last night he began to have some episodes of emesis and has not eaten anything since. He presents floppy, very lethargic, according to the parents, ill appearing, not acting normally and with a decreased level of consciousness. They initially called Dr. Olson's office, who told the patient's mother to proceed to the emergency department immediately. The patient's birth weight was 6 pounds 11 ounces. The patient was delivered at 38 weeks. The patient's apgar scores were 8 and 8. The patient after birth had some difficulty with feeding and emesis and very poor feeding and was transferred to the special care nursery. The patient was in the special care nursery for approximately a week according to the mother. The patient was discharged home with a weight of 6 pounds 6 ounces. The caretaker states that the patient was seen by Dr. Olson last week and was 8

pounds 10 ounces. There have been no recent illnesses, no sick contacts. The patient has not had an elevated temperature. He had a normal bowel movement yesterday. There is no history of diarrhea. He has been eating okay up until the emesis began yesterday. No other information could be obtained at this time.

PAST MEDICAL HISTORY: None.
SURGICAL HISTORY: None.
FAMILY HISTORY: None.
SOCIAL HISTORY: The patient's immunization are up-to-date.
MEDICATIONS: None.
ALLERGIES: No known drug allergies.

REVIEW OF SYSTEMS: All systems are reviewed and are as stated above, otherwise negative per parent.
PHYSICAL EXAMINATION:
CONSTITUTIONAL: The patient appears very floppy, ill appearing, ashen in color, not moving extremities. The patient's eyes are open and staring to the right. Initial pulse is 170, temperature is 97.0 rectally. The patient does not respond to noxious stimuli, mainly an interosseous IV placement.
EYES: The patient's eyes are deviated to the right, but does look to the left. The eyes appear sunken in. They are dry appearing. There is no conjunctivitis, subconjunctival hemorrhage or other injury seen to the eye. The patient's pupils are dilated and very minimally reactive to light.
HENT: The anterior fontanelle is soft and flat. The head is atraumatic and normocephalic. Ears are clear bilaterally. Nasal passages are clear. Mucous membranes are moderately dry appearing. Tongue is midline. Oropharynx is otherwise clear and patent. The patient holds his head in a constant tilt to the right.
NECK: Supple, no meningeal signs. Trachea midline. No masses or thyromegaly. There is no nuchal rigidity.
CARDIOVASCULAR: Heart rate is tachycardic. There are no murmurs, rubs or gallops. Peripheral pulses are weak in all four extremities. There is no peripheral edema.
RESPIRATORY/CHEST: Breath sounds clear and equal bilaterally. No rales, rhonchi, or wheezes. No retractions.
GASTROINTESTINAL/ABDOMINAL: Abdomen soft without tenderness or distention. No palpable masses or organomegaly. No peritoneal signs.
MUSCULOSKELETAL: No cyanosis. No joint swelling. Normal muscle tone.

Name	Date of Birth	Room	Exam Date	Encounter#	MR#
Baumer, Philipp	**08/16/2003**	**ER**	**10/03/03**	**E02513597**	**M0764386**

NEUROLOGICAL: The patient is very floppy and ill appearing. He moves his extremities very minimally and does not respond much to pain with interosseous IV.
SKIN: The patient's skin is pale and ashen in color. The patient's skin is doughy and tents very easily, indicating severe dehydration. There are no rashes or bruising seen at this time. There are no external signs of injury upon examination.

MEDICAL DECISION MAKING: The patient is seen and examined. The patient is brought back quickly to the pediatric trauma suite and resuscitation begins. The patient is given oxygen per nasal cannula. He is placed on a cardiac monitor, shows a heart rate of 170. Rectal temperature is 97.0. The patient does appear to be in a septic-like picture at this time. Concerns for overwhelming sepsis or other etiology are discussed with the mother and the caretaker at this time. Initial IV attempts are unsuccessful. Therefore, an interosseous IV line is established in the right anterior tibia. That interosseous line fails, and infiltration does occur. Therefore, an attempt is made on the left tibia, which also fails at this time. Right interosseous IV line is established. Fluids are administered, and the patient is given an 8 cc dose of D25 because the patient is hypoglycemic with an initial glucose of 18. The I/O has fluid leaking into leg so second Interosseus is started. . A scalp vein is subsequently obtained, and the patient is given glucose through that scalp vein with initial normal saline bolus of 60 cc. Maintenance infusion is then administered. Second I/O is questionable, but no swelling, and is removed. The patient is quickly given 75/kg dose of Claforan and 100 mg/kg dose of ampicillin intravenously. Laboratory studies are ordered. Catheterized urinalysis is sent. Blood culture times one is sent and is pending at the time of this dictation. A portable chest x-ray is also obtained. Subsequent heel stick measurements are normalized. Please see nursing notes for subsequent values. A urinalysis is obtained, which shows 2-5 red blood cells. Urine white blood cells are 5-10. There is a trace bacteria. Leukocyte esterase and nitrites are negative.

Because of the patient's ill appearance, Dr. Maiteh is contacted. Initially recommends that Dr. Mehdizadeh come and assess the patient. A call was place to Dr. Mehdizadeh, and he was asked to come see the patient immediately. The patient was then assessed by Dr. Mehdizadeh initially immediately. During the resuscitation, it appeared that the patient may have had a seizure

activity, which was witnessed by Dr. Mehdizadeh. An EEG was performed, and those results are pending at the time of this dictation. Initial chest x-ray showed no acute infiltrates, effusions or pneumothorax. Initial blood gas shows that the patient is acidotic. Please see the respiratory sheet for exact details. The patient is given several doses of bicarbonate to correct that acidosis. Initial laboratory studies show a BUN and creatinine of 109.3 and 1.7, which represent severe dehydration. Potassium is 7.6. Carbon dioxide is 14.5. White blood count was 24.5. Hemoglobin and hematocrit are decreased at 6.2 and 17.8. Blasts are high at 4.0. The peripheral smear shows many schistocytes and spherocytes and vacuolized PMNs, which could indicate peripheral hemolysis at this time. An LDH level was obtained and is elevated at 618. The patient did have an episode of apnea for a period of time, which was witnessed by Dr. Mehdizadeh, and the patient was intubated by Dr. Mehdizadeh without any difficulty. The patient was administered phenobarbital before the intubation because of the patient's possible seizure activity, which then subsequently prompted the EEG test. A Gastroccult is positive after an NG tube was placed. Concerns for a hemolytic uremic syndrome or severe sepsis are the etiologies discussed with the family in detail, and it is recommended the patient be transferred to a pediatric ICU. Initially Dr. Bardwash (phonetic) from William Beaumont pediatric ICU is contacted, and he states that they would not be able to effectively take care of this patient secondary to the patient may need dialysis. A call is then placed to the PICU fellow at Children's Hospital, Dr. Alviedo, who states that he would accept the patient, and the case is discussed with Dr. Johnson, the pediatric intensivist at Children's Hospital, who agreed to take the patient's admission. I spoke with Dr. Johnson in detail about the patient's condition, and she agreed with the transfer. The proper paperwork was filled out. The pediatric ICU transport team does arrive, assesses the patient, and the patient is initially transported with stable vital signs. The patient is currently being ventilated and in stable condition. Fluids are being maintained through an scalp intravenous line. The patient undergoes multiple reassessments by myself and Dr. Mok, as well as Dr. Mehdizadeh in the emergency department. Clinically the case is discussed with the clinical social worker, and the patient was seen by the clinical social worker, who made an assessment of the patient's condition, as well as with the patient's caretakers at home. A 3200 form was filled out by myself. No CT scan was performed before the patient was transported per request by Dr. Johnson. There is still a concern at this time that patient may have an intracranial hemorrhage. This will be evaluated at Children's Hospital. The patient is

stable at the time of his transfer.

DISPOSITION: The patient transported to Children's Hospital in stable condition.

Job No.: 28525 /js
DD: 10/03/2003
DT: 10/03/2003 17:43:59
D: Chad Carman, DO

This document was electronically signed by CHARLES D. MOK, DO on 10/04/2003 13:28:46.
TEACHING PHYSICIAN ADDENDUM: Added at the time of electronic signature by C. Mok
I was present during the resident's history and exam. I discussed the case with the resident and agree with the findings and plan as documented.
Procedures supervised.
One hour critical care time performed.
Bilateral Interosseus lines performed.
Disc with Neurologist/neonatologist
Electronically signed C. Mok, D.O

Mount Clemens General Hospital

EEG Report

1000 Harrington Blvd. Mt. Clemens, MI 48043 (586) 493-8000

Name	Date of Birth	Room	Exam Date	Encounter#	MR#
Baumer, Philipp	**08/16/2003**	**ER**	**10/03/03**	**E02513597**	**M0764386**

REPORT COPIES TO:
Attending: CHARLES D. MOK, DO
Referring:
Family: LUCILA OLSON, M.D.

No.: 03-901

HISTORY:
This is a child who was brought in unresponsive with nonreactive, dilated pupils.

FINDINGS:
There was polymorphic 1 to 2 Hz delta activity distributed throughout both hemispheres, which was unreactive. At times, there was 4 Hz theta noted in the left hemisphere. There was no reactivity with the background. The activity was of very low amplitude. There were some intermittent sharp waves noted bihemispherically.

CLINICAL INTERPRETATION:
This electroencephalogram is abnormal for the age of the patient. The diffuse low amplitude slowing as well as the unreactivity indicates diffuse neuronal dysfunction, consistent with an encephalopathic process. In addition, the sharp waves do indicate underlying cortical irritability and do indicate the potential for seizures.

Job No.: 21224 /ew
DD: 11/08/2003
DT: 11/08/2003 16:45:08

This document was electronically signed by RASHMI GUPTA, MD on 11/10/2003 08:41:27.

Children's Hospital, Oct. 4–30, 2003 Pages 27–30

RESULTS

NAME: BAUMER PHILIPP **MR #:** 890116781

DATE OF EXAM: 10/4/2003 **ACCESSION #:** 5543220

PHYSICIAN: JOHNSON YVETTE RENEE

CT-Head (W/O Contrast) AT 2139HOURS:

IMPRESSION

854.02

CT HEAD WITHOUT CONTRAST

CLINICAL HISTORY: One-month-old male with seizures, abnormal EEG.

TECHNIQUE:
1. No sedation was required.
2. Unenhanced axial CT of the head was performed with 5-mm sections.

FINDINGS:
1. The patient is intubated. There is patchy hypoattenuation throughout the supratentorial brain, predominantly in the frontal and temporo-occipital regions with loss of gray-white interface. These findings are more pronounced on the right side. Patchy areas of increased intensity are also seen in the high parietal region, to a lesser degree the left parietal region medially. These are consistent with parenchymal hemorrhage. Also seen is a subdural hemorrhage in the interhemispheric fissure, both anteriorly as well as in the parietal region and layering along the tentorium. There is asymmetric extraaxial fluid collection in the left frontoparietal region with mixed intensity, slightly higher than CSF. The asymmetry and the attenuation suggest subacute or chronic subdural hematoma.
2. The ventricles are not enlarged. There is hemorrhage within the lateral ventricles, layering in the occipital horns. The basal ganglia signal is relatively spared. The posterior fossa is also relatively spared. There is prominence of the retrocerebellar fluid space.
3. A large diastatic fracture is seen in the right parietal bone. There is opacification of the rudimentary mastoids and middle ears with fluid level in the right mastoid. However, no definite fracture is identified involving the petrous temporal bone on the right side.

IMPRESSION:
THERE ARE MULTIPLE AREAS OF PARENCHYMAL HEMORRHAGE, SUBDURAL HEMORRHAGE INCLUDING INTERHEMISPHERIC HEMORRHAGE AND HEMORRHAGE ALONG THE TENTORIUM, AN INTRAVENTRICULAR HEMORRHAGE. ALSO, MULTIPLE AREAS OF HYPOATTENUATION ARE SEEN SUPRATENTORIALLY, MORE MARKED ON THE RIGHT SIDE WITH OBSCURATION OF GRAY-WHITE MATTER INTERFACE. THESE LIKELY REPRESENT HEMORRHAGIC AND NON HEMORRHAGIC AREAS OF CONTUSION AND/OR ASSOCIATED INFARCTS. ALSO SEEN IS EXTRAAXIAL FLUID COLLECTION IN THE LEFT FRONTOPARIETAL REGION OF SLIGHTLY HIGHER ATTENUATION THAN CSF WHICH MAY REPRESENT SUBACUTE OR CHRONIC HEMORRHAGE. THERE IS RIGHT PARIETAL DIASTATIC FRACTURE. THE CONSTELLATION OF THE ABOVE FINDINGS IS HIGHLY SUGGESTIVE OF NON-ACCIDENTAL TRAUMA. THESE FINDINGS WERE CONVEYED BY DR. PAPPAS TO DR. BYDON, NEUROSURGERY RESIDENT. THESE WERE ALSO DISCUSSED BY DR. MODY WITH DR. BENJAMIN ON 10/5/03.

MWPS/LKA/5273032

FINAL
Dictated By:
And Verified By: MODY, SWATI S

Electronically Signed Date: 10/23/03 08:26
Date Transcribed: LKA 10/06/03 14:11

I certify that I personally viewed the images and performed the interpretation of this procedure.

Transcribed By: : 10/23/2003 : 0826
Approved By:

Radiologist: UNKNOWN

RESULTS

NAME: BAUMER PHILIPP **MR #:** 890116781

DATE OF EXAM: 10/9/2003 **ACCESSION #:** 5552978

PHYSICIAN: HAM STEVEN

CT-Head (W/O Contrast) AT 1402HOURS:

IMPRESSION

854.02

CT OF THE HEAD WITHOUT CONTRAST:

CLINICAL: One-month-old caucasian male with new onset of seizures. Question of nonaccidental trauma, possible shaken baby syndrome.

TECHNICAL:
Multiple axial images were obtained at 5-mm slices throughout the brain without contrast. The examination was compared to previous from October 4, 2003. No sedation was required.

FINDINGS:
In the interval, the right-sided anterior frontal ventricular shunt has been placed with its tip in the region of the left basal ganglia. The anterior horn of the right lateral ventricle appears prominent.

As previously described, there are multiple areas of hemorrhage within the supratentorial parenchyma (right greater than left) and also subdural in location layering along the tentorium cerebelli and the falx. These appear essentially unchanged. The intraventricular hemorrhage that was previously described does appear improved.

There are multiple areas of hypoattenuation of the supratentorium predominantly in the frontal and temporo-occipital regions (right side greater than left). There are multiple areas of hyperattenuation seen in a gyral pattern, which is representative of acute cortical necrosis.

IMPRESSION:
1. INTRAVENTRICULAR HEMORRHAGE APPEARS IMPROVED. SUBDURAL HEMORRHAGE AND PARENCHYMAL HEMORRHAGE APPEARS ESSENTIALLY UNCHANGED.
2. INTERVAL PLACEMENT OF RIGHT-SIDED ANTERIOR FRONTAL SHUNT WITH ITS TIP IN THE REGION OF THE LEFT BASAL GANGLIA.

3. MULTIPLE AREAS OF HYPOATTENUATION ONCE AGAIN SEEN IN THE SUPRATENTORIUM, ALTHOUGH THESE DO APPEAR IMPROVED. THE RIGHT-SIDED SUPRATENTORIAL IS INVOLVED TO A GREATER THAN EXTENT THAN THE LEFT. THESE FINDINGS ARE CONSISTENT WITH THE PATIENTS HISTORY OF SHAKEN BABY SYNDROME.

MWPS/NJD 5288080

Dictated by Dr. Rocky Saenz,
Resident

FINAL
Dictated By:
And Verified By: SMITH, WILBUR L MD

Electronically Signed Date: 10/12/03 08:04
Date Transcribed: NJD 10/10/03 18:24

I certify that I personally viewed the images and performed the interpretation of this procedure.

Transcribed By: : 10/12/2003 : 0804
Approved By:

Radiologist: UNKNOWN

RESULTS

NAME: BAUMER PHILIPP **MR #:** 890116781

DATE OF EXAM: 10/30/2003 **ACCESSION #:** 5597199

PHYSICIAN: JOHNSON YVETTE RENEE

MRI-Brain/Stem (W/O Contrast) AT 1902HOURS:

IMPRESSION

995.55, 434.91

MRI OF THE BRAIN:

CLINICAL: Nonaccidental trauma, shaken baby syndrome, skull fracture, intracranial bleed.

TECHNICAL:
Multiplanar, multisequential, MRI imaging of the head was performed without intravenous gadolinium contrast material. Comparison is made to a prior CT examination dated October 9, 2003. This patient was sedated in the NICU.

FINDINGS:
There is evidence of a diastatic right parietal skull fracture. All sequences demonstrate multiple large areas of cystic encephalomalacia with associated parenchymal hemorrhage of various ages. Gradient-echo imaging was performed and demonstrates the presence of hemosiderin within the occipital white matter on the right and the periventricular white matter on the left.

There are multiple extraaxial fluid collections noted bilaterally, subarachnoid and subdural in location. There is supratentorial ventriculomegaly noted with a right frontal ventriculostomy catheter stable in position since the prior CT. Inversion/recovery imaging was performed in the axial plane and does demonstrate multiple foci of hyperintensity bilaterally within the right occipital and left parietal lobes consistent with acute hemorrhage. There is also the suggestion of parenchymal volume loss near the convexities.

Diffusion-weighted imaging was also performed and demonstrates no additional abnormality.

IMPRESSION:
1. THERE IS SEVERE, DIFFUSE, CYSTIC ENCEPHALOMALACIC CHANGES WITH BLOOD IN VARIOUS STAGES OF EVOLUTION, AT LEAST SOME OF WHICH IS LIKELY CHRONIC AS THERE IS HEMOSIDERIN DEMONSTRATED ON GRADIENT ECHO IMAGES.
2. THERE IS SUPRATENTORIAL VENTRICULOMEGALY.
3. FLAIR IMAGING DOES DEMONSTRATE SEVERAL FOCI OF ACUTE BLOOD, AS DESCRIBED ABOVE.
4. THERE ARE EXTRAAXIAL FLUID COLLECTIONS NOTED IN BOTH THE SUBARACHNOID AND SUBDURAL LOCATION.
5. RIGHT VENTRICULOSTOMY SHUNT CATHETER STABLE IN POSITION SINCE THE PRIOR CT EXAMINATION.

MWPS/NJD 5345481

CLASSIFICATION 2
FINAL ICD 431

FINAL
Dictated By: HASS, MARK
And Verified By: SLOVIS, THOMAS L MD

Electronically Signed Date: 10/31/03 17:35
Date Transcribed: NJD 10/31/03 14:03

I certify that I personally viewed the images and performed the interpretation of this procedure.

Transcribed By: : 10/31/2003 : 1734
Approved By:

Radiologist: UNKNOWN

RESULTS

NAME: BAUMER PHILIPP **MR #:** 890416781

DATE OF EXAM: 10/6/2003 **ACCESSION #:** 5544006

PHYSICIAN: JOHNSON YVETTE RENEE

Bone Survey-Infant<2 Years Old AT 1116HOURS:

IMPRESSION

432.9

BONE SURVEY:

CLINICAL: Intracranial hemorrhage and skull fracture, evaluate for other fractures.

FINDINGS:
Frontal and lateral views of the skull show a large right parietal skull fracture extending from the lambdoid suture forward to the coronal suture. There is an intracranial catheter and monitor wire. The catheter enters on the right side near the level of the coronal suture and the catheter passes medially and inferiorly to lie just to the left of midline superior and posterior to the sella turcica.

A frontal view of the chest along with oblique views of the ribs shows no evidence of rib fracture. The heart size is normal. The pulmonary vascularity is normal. No diaphragmatic or pleural abnormalities are evident. The visualized bowel gas pattern is unremarkable.

Frontal and lateral views of the spine show the vertebral body heights and disc spaces to be well maintained. No evidence of fracture or dislocation or dislocation is noted in the spine.

Views of both the left and right upper extremities show no fracture deformity, lytic or destructive process. Intravenous catheter overlies the left hand and the right antecubital region. There is some soft tissue swelling on the dorsal aspect of the hand. The catheter entering the right antecubital region appears to be a PICC line with the catheter passing up to the chest and into the region of the right atrium and possibly right ventricle. The catheter has been pulled back from the left pulmonary artery where it was seen on the prior study.

Views of both the left and right lower extremities show no osseous, articular or soft tissue abnormalities.

A frontal view of the pelvis shows no ossification of the femoral heads at this point, however, no osseous abnormalities are identified. The visualized bowel gas pattern is felt to be nonobstructive.

IMPRESSION:
FRACTURE IN THE RIGHT PARIETAL BONE WITH NO OTHER FRACTURE SEEN IN THE SKELETAL SYSTEM.

MWPS/NJD 5285195

FINAL
Dictated By:
And Verified By: EGGLESTON, DANIEL E MD

Electronically Signed Date: 10/10/03 17:18
Date Transcribed: NJD 10/10/03 09:17

I certify that I personally viewed the images and performed the interpretation of this procedure.

Transcribed By: : 10/10/2003 : 1718
Approved By:

Radiologist: UNKNOWN